ASTHMA ACTION PLAN

To be completed and signed by Physician

Effective Date: _____ to _____		
Student Name:	Date of Birth:	School Building:
Parent(s)/Guardian(s):		Phone: Alternate:
Emergency Contact:		Phone: Alternate:
Physician Name:		Phone: Fax:
Physician Signature:		Physician Emergency Phone:
Is the student able to self-medicate: ○Yes ○ No		

Go (Green)	Use these medications every day		
You have all of these:	Medication	How much to take	When to take
- Breathing is good - No coughing or wheezing - Sleeping through the night - Can work and play			
	For asthma with exercise, take:		
Peak Flow above: _____			

Caution (Yellow)	Continue with green zone medications and add:		
You have any of these:	Medication	How much to take	When to take
- First sign of a cold - Exposure to known trigger - Cough - Mild wheeze - Tight chest - Coughing at night			
Peak flow from ____ to ____			

Danger (Red)	Take these medications and call your doctor		
Your asthma is getting worse *fast*	Medication	How much to take	When to take
- Medicine is not helping within 15-20 minutes - Breathing is hard and fast - Nose opens wide - Ribs show - Lips and fingernails are blue - Trouble walking and talking			
Peak flow from ____ to ____			

Special Instructions:

Check all items that trigger your asthma and things that could make your asthma worse:

- ○ Chalk Dust
- ○ Cigarette smoke and second hand smoke
- ○ Colds/Flu
- ○ Dust mites, dust, stuffed animals, carpet
- ○ Exercise
- ○ Mold
- ○ Ozone Alert days
- ○ Pests – rodents and cockroaches
- ○ Pets – animal dander
- ○ Plants, flowers, cut grass, pollen
- ○ Strong odors, perfumes, cleaning products, scented products
- ○ Sudden temperature changes
- ○ Wood smoke
- ○ Foods: _____ _____
- ○ Other: _____ _____

updated 5/27/25en

AUTHORIZATION/CONSENT FOR MEDICATION/TREATMENT AT SCHOOL

Student's Name: _____ Date of Birth: _____School Year_____

Diagnoses/Condition: _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Health treatments and mediations must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually**.** Providers complete Part 1 below and must sign form- Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below-Part 2.

PART 1: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

Medication/Treatment: _____

Strength/Dosage/Route_____

Time(s)/Frequency to be given at school: _____

Desired action of medication: _____

Student can self-carry the prescribed medication ☐ (check box if yes)

Recommendations, Special Considerations, Side Effects, Precautions, Allergies:

_____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and healthcare provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be share with appropriate staff for emergency care. I will not hold the CPS Board of Education or it's personnel responsible for complications related to the medication. Medication that is not picked up by the last day of school will be disposed of at local pharmacy or local police department for controlled substances.

Physician/Provider: _____ _____

Print Name Signature

_____ _____ _____

Date Phone Fax

Parent/Guardian: _____ _____

Print Name Signature

_____ _____ _____

Date Phone Fax

Form 5330 F1- 5/20/2025

Charlotte Public Schools
378 State Street, Charlotte, MI 48813
Phone: 517-541-5100 Fax: 517-541-5105